DATES OF VISIT: commenced on January 9, 2018 and concluded on January 16, 2019

POC Approved 3/8/19 SHN

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (e) Nursing service (1) and/or (i) General (6).

1. Based on tour and observations of the Autism unit, the hospital failed to ensure a safe environment when personal hygiene liquids were found in an unlocked and unsupervised room. The findings include:
   a. A tour of the Autism unit (child and adolescent) was conducted on 1/10/19 at 9:30 AM with the Unit Manager and Clinical Coordinator. Patient #11's bedroom door was noted to be open and unattended. In the room, Patient #11 had a supply basket that contained liquid body wash and liquid deodorant. It was identified that the patient had recently taken a shower and the shower supplies were not returned to staff and/or secured and should have been. The unit manager identified that it was the practice on the Autism unit to secure all toiletry products.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (e) Nursing service (1) and/or (i) General (6).

2. Based on tour, observation, interview and policy review the facility failed to ensure for 2 of 8 crash carts that the carts were checked per policy, failed to ensure that expired items were removed from the cart and/or failed to ensure that the emergency equipment (defibrillator) on the emergency cart was checked daily as required by hospital policy. The findings include the following:
   a. Tour of the CMU on 1/9/19 at 9:00 AM identified that the emergency cart supply list was located on the crash cart. The list indicated a line listing of the supplies in the carts and expiration dates if applicable. The list indicated that the cart had been checked by Materials Management in January 2018, March, May and November 2018. Review of the list indicated that the IV started kit expired in May 2018, gloves in August of 2018, blood gas kits in November 2018, an airway in June 2018 and one bad of IV fluids in March 2018.

      Interview with the Nurse Manager on 1/9/18 at 10:00 AM indicated that when nursing checks the emergency cart they are checking the function of the defibrillator and that the crash cart is locked not if the contents are outdated and that is the responsibility of materials management.

   b. Tour of COU on 1/9/19 at 11:00 AM identified that the emergency cart supply list indicated that the supplies had been checked in January of 2018 and September of 2018. Review of COU form on 1/9/19 indicated that four 10 ML prefilled syringes expired in March of 2018, a filter needle expired in March of 2018, pneumothorax kit expired in November of 2018, four pairs of sterile gloves expired in August of 2018, blood gas kits in February of 2018, four airways that expired in May of 2018 through December of 2018, 8 Bags of IV solution,

two trachs and electrodes that were expire.

Subsequent to inquiry all the carts in the hospital were checked to ensure outdated supplies were not present. Review of the policy indicated Materials Management is responsible for ensuring that each cart is stocked and maintained. The policy indicated that emergency carts will be checked daily by the nurse and that a detailed inventory of the items will be managed and restocked by materials management. The policy does not identify what the emergency cart checks entail. i.e. checking supply expiration dates.

c. On 01/09/19 9:30 AM, during a tour of the Autism Unit along with the Director of Engineering and Facilities it was observed during a review the emergency cart that the daily logs indicated that the defibrillator was tested daily however review of the testing strip indicated that it was tested on 01/04/19, 01/06/19 and 01/08/19 every other day. Subsequent interview with the Autism Unit Manger and her review of the logs and testing strips confirmed this finding that the testing had not been done daily.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing service (1).

3. Based on observation, interview and policy review the facility failed to ensure for one of three dressing changes observed (Patient #2) that the dressing change was completed per the policy. The finding includes the following:
   a. Observation of Patient #2's Ventricular Assisted Device (VAD) dressing change was completed on 1/9/19 at 9:45 AM. RN #1 was observed to open the sterile pack and place one set of sterile gloves on the window sill and the second set of gloves on the bedside table. RN #1 donned one set of sterile gloves and then donned the second set and indicated this was so he could remove the dirty dressing and then remove the top set of gloves and complete the dressing change.

   RN #1 was observed with two sets of sterile gloves on, remove the patient's dressing, discard the dressing and remove the top set of gloves and then proceed to clean the area. At the conclusion of the dressing change the second set of gloves were removed and discarded.

   Review of the policy directed that staff don sterile gloves and prepare supplies, remove old dressing and discard dressing and gloves, perform hand hygiene and don second pair of sterile gloves.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing service (1).

4. Based on clinical record review and policy review the facility failed to ensure for one of two patient's on the CMU (Patient #27) that vital signs were completed every shift as ordered. The

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findings include the following:

a. Review of Patient #27's clinical record with the Nurse Manager on 1/9/19 at 10:30 AM indicated that the patient had coronary artery bypass in October of 2018 and was admitted on 12/24/18 with congestive heart failure. The physician orders dated 12/24/18 directed vital signs every shift. Review of the record indicated that on 1/3/19 the record failed to reflect that vital signs were completed on the day shift. The record failed to reflect that vital signs were completed on the day shift on 1/4/19 and 1/7/19 or of the evening shift on 1/4/19.

Review of the policy for nursing standards for documentation indicated that the RN is responsible to ensure that data gathered by the team is recorded.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing service (1) and/or (i) General (6).

5. Based on observation the facility failed to ensure for 1 of 2 patients on a tube feeding (Patient #26) that the head of the bed was maintained at 30 degrees. The findings include the following:
   a. Patient #26 was admitted on 12/12/18 with Diabetes, Atrial Fibrillation, a PEG and a wound infection. On 1/10/19 at 1:20 PM of Patient #26 was observed during dressing changes of bilateral lower extremities, identified that patient's tube feeding was placed on hold at the initiation of the dressing change. At 1:45 PM the tube feeding alarmed and RN #2 restarted the infusion of the tube feeding, while the patient remained flat for approximately 15-20 minutes, while the tube feeding was infusing. Review of the care plan 12/13/18 indicated in part that the head of bed elevated at 30 degrees with tube feeding.

   Review of the policy for tube feeding - patient care management protocol indicated to keep the head of bed at 30-45 degree angle or as ordered by the physician when the patient is being tube fed.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical Records (3) and/or (e) Nursing service (1).

6. Based on clinical record review, interview and policy review the facility failed to ensure for 2 of 4 patients experiencing pain (Patients #25 and 18) that the patient's pain was assessed and/or reassessed and/or that the clinical record reflected the need for an increased dose of morphine and/or a bolus dose of Versed. The findings include the following:
   a. Patient #25 was readmitted to the facility on 1/7/19 with chronic kidney disease, Diabetes, peripheral vascular disease, coronary artery disease and gangrene of both feet. The physician's order dated 1/7/19 directed hydromorphone 0.5 mg via the G-tube every four hours for a moderate (4-7) pain level. Review of the medication administration record (MAR) with the Unit Manager indicated that on 1/7/19 at 6:20 PM the patient was medicated with Hydromorphone 0.5 mg for a pain level of 6 however the record failed to reflect a reassessment to determine efficacy of the intervention. Patient #25's MAR

indicated that on 1/9/19 at 3:30 AM and 11:25 AM hydromorphone 0.5 mg via the G-tube was administered however, the clinical record failed to reflect a pre and/or post assessment of the patient's level of pain.

b. Patient #18 was admitted on 7/12/18 for palliative care related to ESRD. Review of the MAR indicated that the physicians order dated 7/12/18 directed Morphine 250 mg in 250 cc's at 10 mg/hr may increase by 2 mg up to a maximum of 20 mg/hour for pain. The physician's order dated 7/19/18 directed MSO4 8 mg IV every 2 hours prn for discomfort.

Review of the IV infusion record indicated that on 7/23/18 at 10:15 AM, 1:35 PM, 6:00 PM and 9:30 PM the patient received 8 mg of Morphine bolus however the clinical record failed to reflect a pain assessment and /or a note for the rationale for the medication.

The infusion record indicated that on 7/27/19 at 2:30 PM and 6:30 PM the patient received an 8 mg bolus and on 7/28/19 at 7:55 AM, 10:00 AM, 5:10 PM and 10:15 PM the patient received 8 mg of Morphine bolus however the clinical record failed to reflect a pain assessment and /or a note for the rationale for the medication.

Interview with the Unit Manger on 1/11/19 at 10:00 AM indicated that pain assessments are completed when The Pain policy indicated that the effectiveness of interventions will be assessed, pain assessments using the pain scale will be done prior to and after all PRN pain medications.

Review of Patient #18's Intravenous Infusion record indicated that on 7/17/18 at 8:55 PM the patient was receiving Morphine 250 mg in 250 cc's at 16 mg per hour. The IV record indicated that at 10:45 PM the Morphine infusion rate was increased to 18 mg per hour however the clinical record failed to reflect a rationale for the change and/or a pain assessment.

Review of Patient #18's physician orders dated 7/16/18 directed Versed 100 mg in 100 cc's IV at 1 mg per hour for seizures and twitching. The 7/19/18 physician order directed 2 mg of Versed IV for seizures every 2 hours as needed. The IV record indicated that on 7/27/18 at 5:10 PM the patient received a 2 mg bolus of Versed. The record failed to reflect the reason for the bolus dose.

Review of the policy indicated that all PRN medications should have documentation of drug, dose, route, date, time reason for administration and effectiveness. The Nursing Documentation policy indicated the nurse administering medications will document the administration on the MAR.

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The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing service (1).

7. Based on clinical record review, interview and policy review the facility failed to ensure for one patient (Patient #18) that care was provided per the plan of care. The findings include the following:
   a. Patient #18 was admitted on 7/12/18 for palliative care related to ESRD. Review of the care plan dated 7/11/18 indicated that the patient's active problems were in part polypharmacy, psychosocial, nutrition, self-care deficit and skin integrity. Review of the Skin integrity problem indicated that the interventions identified were in part turn and reposition every 2 hours.

      Review of the nursing flow sheets for the period of 7/12/18 through 7/29/18 indicated that the patient was turned and repositioned every three hours.

      Review of the policy indicated that the care plan contains measureable outcomes and interventions for the patient's medical, surgical, rehab and psychosocial needs.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing service (1) and/or (i) General (6).

8. Based on observation and interviews during tube feeding administration and/or medication pass it was identified that for 1 of 2 patients (Patient #19) the tube feeding was not administered according to physician orders The findings include:
   a. Patient (P.) #19 was admitted to the facility with diagnoses that included cervical injury, tracheostomy and gastrostomy tube. According to physician orders dated 12/27/18 P#19 was to receive Neocate Splash unflavored 1 container 6 times a day GT over 1 hour via feeding pump or as a "slow bolus" per patient preference.

      During an observation on 1/10/19 at 1:50 PM with Unit Manager (UM) #1 and the Vice President (VP) of Nursing, Licensed Practical Nurse (LPN) #1 was noted to administer one container of Neocate Splash. LPN #1 poured the container of formula into a cup and then withdrew the formula from the cup with a 60 millileter (ml.) syringe, inserted the syringe into the GT and compressed the plunger administering the formula in less than 1 minute. LPN#1 proceeded to repeat the process three times all in the same manner. Upon interview LPN#1 was asked if P#19's tube feeding was able to be administered using gravity to which he/she replied "Yes".

      Interview and review of physician order with Unit Manager #1 on 1/10/19 at 2:00 PM indicated the bolus feed P#19 was administered by LPN#1 should have been administered

according to physician order (slow bolus) and/or policy and not as a rapid bolus.

Patient Care Management protocol for feeding tubes indicated tube feeding type, amount and rate will be ordered by the physician/APRN in addition policy for tube feed methods identified tube feeding by gravity will usually take 10 to 40 minutes and slight pressure may be used to begin flow then use gravity method.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (d) Medical Records (3) and/or (e) Nursing service (1).

9. Based on clinical record review and interview with staff for 1 of 3 patients reviewed for suicide risk screening (Patient #10) the hospital failed to ensure that the screen was accurately completed and/or that a Psychologist or Psychiatrist was notified of the results of the screen. The findings include:
   a. Patient #10 was admitted on 12/31/18 with a diagnosis of Autism. A suicide risk screen dated 12/31/18 identified that the patient had a history of psychiatric treatment. Based on the history of psychiatric treatment, there is a prompt to identify if the patient is in current psychiatric treatment, which was blank. According to the screen, it is required that staff notify a Psychologist or Psychiatrist after completion of the screen. Interview and review of the clinical record with the Clinical Coordinator on 1/10/19 at 11:00 AM identified that there was no evidence that the notification occurred and there was no clinical note by a Psychologist or Psychiatrist.

      In addition, an "environmental check tool-suicide risk" screening is to be completed. Review of the screening tool identified that Patient #10's bed and clothing including pantyhose were removed. Interview with the Clinical Coordinator on 1/10/19 at 11:00 AM identified that the bed was not removed and that items in the screening tool were inaccurate.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical Records and/or (e) Nursing service (1).

10. Based on clinical record review, and interview the facility failed to ensure that for one of three patient's (Patient #26) with wounds that dressing orders were accurately transcribed. The findings include the following:
    a. Patient #26 was admitted on 12/12/18 with Diabetes, Atrial Fibrillation, a PEG and a wound infection. Review of Patient #26's clinical record indicated that on 1/4/19 the patient had his/her sacral wound debrided. Review of the physician's orders dated 1/4/19 directed wet to dry dressing to the sacrum bid. Review of the treatment record for Patient 26 indicated that the patient's wet to dry dressing was completed once a day for the period of 1/5/19 through 1/10/19.

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Interview with the Nurse Manager on 1/10/19 at 11:00 AM indicated that the order was entered in the computer and was not seen by the staff because the treatment orders should written in the chart. The Unit Manager indicated that the on-call physician must have been aware that not all orders are entered into the computer.

In addition review of the treatment record indicated that the dressing was not completed on 1/8/19 however the record failed to reflect the reason for the omission.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical Records (3).

11. Based on clinical record review, interview and policy review the facility failed to ensure that for three records reviewed that an accurate clinical record was maintained. The findings include the following:
    a. Review of Patient #26's treatment record with the Manager on 1/10/19 also indicated that the patients tube feeding was held on 1/5/19 and 1/6/19 and the record failed to reflect the rationale. However review of the intake and output record indicated that the tube feeding was administered.

       The policy indicated that all medications that are held will be marked as not done and documentation indicating why it was held will be recorded.

    b. Patient #25 was readmitted to the facility on 1/7/19 with chronic kidney disease, Diabetes, peripheral vascular disease, coronary artery disease and gangrene of both feet. The physician's order dated 1/7/19 directed hydromorphone 0.5 mg via the G-tube every four hours for a moderate (4-7) pain level. Review of the pain assessment form indicated that on 1/8/19 at 5:24 PM and on 1/11/19 at 3:40 AM the patient had an elevated pain level and was medicated with hydromorphone 0.5mg via the G-tube however review of the MAR with the Manager failed to reflect documentation of the medication being administered.

       Review of the policy indicated that the MAR is necessary to keep a record of all medications the patient is receiving. All PRN medications should have documentation of drug, dose, route, date, time reason for administration and effectiveness.

    c. Patient #18 was admitted on 7/12/18 for palliative care related to ESRD. Review of the care plan dated 7/11/18 indicated that the patient's active problems were in part polypharmacy, psychosocial, nutrition, self-care deficit and skin. The self-care deficit problem indicated that the patient was dependent on staff for all ADL's, patient unable to wash upper body

       Review of the nursing flow sheets with Unit Manger #1 on 1/14/19 at 9:30 AM for the period of 7/12/18 through 7/29/18 indicated that the patient received a bed bath on 7/17/18, 7/18/18, 7/24/28 and 7/25/28 (4 out of 17 days). The Unit Manager indicated that staff

should have documented the bath on the flow sheets but she is confident that bed baths were administered.

d. Patient #18 was admitted on 7/12/18 for palliative care related to ESRD. Review of the MAR indicated that the physicians order dated 7/12/18 directed morphine 250 mg in 250 cc's at 10 mg/hr may increase by 2 mg up to 20 mg/hour for pain. Review of the MAR indicated that the first bag was hung at 7/13/18 at 6:25 PM. Review of the pharmacy documentation with the Unit Manager indicated that although it was not documented in the clinical record the first bag was hung on 7/12/18 at 4:10 PM.

Review of the policy indicated that the MAR is necessary to keep a record of all medications the patient is receiving. The Documentation policy indicated that entries regarding patient care must be completed as close as possible to the time of the occurrence.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (f) Diagnostic and therapeutic facilities and/or (i) General (6).

12. Based on medical record review, review of facility documentation, review of facility policies, observations and interviews for one of two patients reviewed for radiological services (Patient #22 & Patient #23), the facility failed to ensure that lead shielding use during the procedure was documented. The finding includes:
    a. A tour of the Radiology department was conducted on 1/10/19 with Radiology Technician #1 (RT). Observations identified stationary and portable x-ray equipment and multiple lead shielding for the body to include thyroid collars and aprons.

    Patient #22's diagnosis included dysphagia and cerebral ataxia. The out-patient physician's order dated 1/3/19 directed modified barium swallow. The modified barium swallow report identified that the test was performed on 1/9/19 in the radiology department. Review of procedure documentation and interview with RT #1 on 1/10/19 at 2:36 PM indicated that P#22 was protected with a lead apron during the procedure, he could have documented this in the comment section of the procedural notes and did not do so.

    Patient #23 was four years old and diagnosis included seizure disorder. A physician's order dated11/26/18 directed to x-ray of the left 2nd toe for possible fracture. Review of P #23's procedure documentation and interview with RT #1 on 1/10/19 at 3:10 PM noted that the x-ray was performed at bedside, he always utilizes lead shielding on patients and the protection used was not documented.

    Interview with the Regional Radiology Manager on 1/11/19 at 11:09 AM indicated that there was a place in the procedural documentation to answer yes or no for lead protection use for patients who had x-rays and that this had been bypassed for P #22. Further interview identified that the question of whether or not lead protection was used, was not a question

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that populated in the procedural documentation for patients who had undergone fluoroscopic procedures.

The facility policy for radiation safety identified a purpose to minimize radiation exposure to staff and patients. The policy further identified that safety measures included shielding.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (f) Diagnostic and therapeutic facilities and/or (i) General (6).

13. Based on observations during tour of the Department of Radiology, The hospital failed to ensure that appropriate signs were posted to ensure safety. The findings include:
    a. On January 16, 2019 as part of the periodic federal Validation Survey, the Radiology Department of the Hospital for Special Care inspection consisted of a review of records, procedures, equipment and facilities, including the following: (a) in-house physics reports and follow-up corrective actions; (b) personnel dosimetry records; and (c) general safety provisions.

    In the Radiology Department, one item of non-compliance was identified within the scope of the inspection.

    R.C.S.A 19-24-8 (5)(C) requires in part that each area or room in which sources of ionizing radiation other than radioactive materials are used shall be conspicuously posted with the sign or signs bearing the radiation caution symbol and appropriate wording to designate the nature of the source.

    Contrary to the above, the Hospital for Special Care did not have conspicuously posted caution X-Ray signs for some of their diagnostic x-ray rooms or adjacent doors.

    On January 16, 2019 the Hospital for Special Care had already completed posting half of the incorrect signage and expected to complete the rest by the COB that day.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (i) General (6).

14. Based on a tour of the hospital and staff interview, the hospital failed to ensure that the physical environment was designed and constructed to maintain the safety of patients with suicidal tendencies and/or tendencies to cause harm to themselves or others.
    a. On 01/09/19 at 09:30 AM and various times throughout the day, while touring the autism unit and hospital spaces it was observed that the Patient rooms throughout the Autism Unit and NBU3 lacked institutional fasteners throughout for window and door frames and subsequent interview of the Director of Engineering and Facilities indicated that they should

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be tamper resistant institutional fasteners.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (i) General (6).

15. Based on a tour of the hospital and staff interview the hospital failed to ensure that the physical environment was designed and constructed to maintain the safety of patients with suicidal tendencies and/or tendencies to cause harm to themselves or others.
    a. On 01/09/19 at 10:30 AM, during a tour of the Behavioral Unit 2, the surveyor accompanied by the Vice President of Facility and Facility Staff it was observed that in one patient room the patient's adjustable electric bed had an electrical cord in excess of three (3) feet long and not secured and/or removed to prevent a patient from utilizing them as a means of hanging.

Approved
3/8/19
SHN

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3/4/2019
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RE: Unannounced Visits concluding on January 16, 2019

Dear Ms. Newton,

This is in response to the violation letter dated February 22, 2019 finding violations of the Regulations of State of Connecticut State Agencies and/or Connecticut General Statutes requesting a prospective plan of correction from Hospital for Special Care. Hospital for Special Care ("Hospital") has responded with a prospective plan of action as described below.

1. The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (e) Nursing Services (1) and/or (i) General (6).

   Summary of Finding:
   Based on tour and observations of the Autism unit, the hospital failed to ensure a safe environment when personal hygiene liquids were found in an unlocked and unsupervised room.

   Hospital Response:
   The items observed in the patient room during survey were immediately secured. The unit policy is to lock all patient belongings in the patient closet on arrival and after use. Each patient has a locked cabinet for these types of items. In this instance, the patient had recently returned from a shower and the items were not immediately locked up per policy. The staff on the unit was reminded on the proper storage protocol.

   There was no patient harmed from this occurrence.

   ACTION PLAN:
   A review of the environmental safety practices for these personal hygiene items has been initiated with the Autism Unit staff to raise awareness to ensuring security of patient personal products from other patients (as well as the patient themselves). This education will be completed in staff meetings throughout March of 2019. This education is reinforcement of an existing practice and policy.

   TIMEFRAME FOR COMPLETION:
   It is expected that the implementation is already in effect and conducting the review with staff will ensure compliance going forward. The refresher education will be completed by 4/1/2019

MONITORING:
The Unit Operations Manager will review the Environmental Checklist monitors being conducted on the unit and validates that no products are unattended

RESPONSIBILITY:

Compliance with this corrective action monitor is the responsibility of the Unit Operations Manager.

2. The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (e) Nursing Services (1) and/or (i) General (6).

Summary of Finding:
Based on tour, observation, interview and policy review the facility failed to ensure for 2 of 9 crash carts that the carts were checked per policy, failed to ensure that expired items were removed from the cart and/or failed to ensure that the emergency equipment (defibrillator) on the emergency cart was checked daily as required by hospital policy.

Hospital Response:

Hospital policy currently allocates Materials Management Department as responsible for insuring that each adult Emergency Cart is stocked and maintained according to hospital standards. This includes ensuring that the supplies on the cart are not expired. Two of the units identified during survey were on the adult units. As a result, review with materials management staff at the time of survey indicated that the person responsible for these carts was an employee who has since resigned and was not fulfilling the job requirements.

Hospital policy currently identifies that the Autism Inpatient Unit nursing staff will be responsible for the management of their cart. This unit is a locked unit and therefore responsibility was designated to the unit staff to eliminate the need for Materials Management to frequently enter the department. The checks include ensuring that the defibrillator is discharged daily during the cart check. Based on the surveyor findings, it was identified that staff were not following the policy requirements.

Maintaining fully functioning and stocked appropriate supplies is a priority for the hospital.

ACTION PLAN:

To address the concern of expired supplies on the adult crash carts; the replacement staff has been educated on the monitoring practice. The outdated supplies were removed, disposed of, and replaced at the time of survey. The Materials Management General Stores Aides are receiving training on the proper procedures for identifying and replacing outdated supplies.

To address the concern of the defibrillator not being discharged daily as expected; the defibrillator in question was tested same day and confirmed to be operational. The Operations Manager brought this deficiency to the staff on the unit for just in time review of the daily check requirements. In addition to reviewing the proper procedure for testing the defibrillator daily with the unit nurse staff at the time of survey, a validation of the daily checks using the monitor tape record and cross check with the daily monitor log has been initiated. The tape will be retained to ensure validation can occur reliably with two sources of data.

TIMEFRAME FOR COMPLETION:

Outdated supplies were replaced on 1/10/2019.
Material Management Training and random cart inspections will be implemented by 3/15/2019.

The defibrillator test and immediate education was completed on 1/10/2019.
Ongoing validation of the process will continue through 4/1/2019.

MONITORING:

The Materials Management Team Leader will conduct random cart inspections to assure compliance and follow up with identified issues. The crash cart list indicating supplies in cart with expiration dates will now contain the signature of the responsible general stores aide and initialed review of the team leader.

A monitoring process has been established to ensure daily defibrillator checks are being completed. The tape will be retained and reviewed, cross-referenced with the log, to ensure daily checks are being completed.

RESPONSIBILITY:

The Materials Management Team Leader is responsible for the adult unit crash carts supply monitor.

The Nurse Clinical Coordinator of the Autism Unit is responsible for the daily defibrillator monitor.

3. The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (e) Nursing Services (1).

Summary of Finding:
Based on observation, interview and policy review the facility failed to ensure for one of three dressing changes observed (Patient #2) that the dressing change was completed per policy.

Hospital Response:

The organization conducted hospital wide dressing change practice within the last 12 months with nurses. The nurse with the observed deficient practice was not part of that education as he is new to the organization. However, the nurse did receive competency assessment on hire related to dressing changes and did so in accordance with the hospital policy which outlines the donning of one pair of sterile gloves, followed by a removal of the existing dressing, a removal of the first pair of gloves and replacement with a new pair of sterile gloves. Following the survey the nurse was interviewed and realized that he did not practice according to the policy and standard of care. He was aware of the policy and best practice. There have been no other observed deviations from policy observed since survey. The patient did not incur any negative outcome from this occurrence.

ACTION PLAN:

A hospital wide nursing educational initiative to review the policy content has begun. It is directed at all nursing staff to coincide with the annual mandatory education assignments. This will work to ensure that any other nurses whose practice has deviated from the policy will be re-focused on the infection prevention requirements. Education is to be provided over the learning management platform and in the standard unit staff meeting content in the month of March.

TIMEFRAME FOR COMPLETION:

The unit based educational initiative will be completed by 4/1/2019.

MONITORING:

The Nurse Quality Coordinator will conduct observations of dressing changes during the months of April and May on all units to ensure policy is being adhered to. Just in time education and feedback will be provided to the employee and unit clinical leaders.

RESPONSIBILITY:

The Nurse Quality Coordinator is responsible for the monitoring of this action plan.

4. The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 € Nursing service (1).

Summary of Finding:
Based on clinical record review and policy review the facility failed to ensure for one of two patients on the CMU (Patient #27) that vital signs were completed every shift as ordered.

Hospital Response:

This finding was observed on the Cardiac Medical Unit. The hospital policy is to follow the physician orders for vital signs. Oversight is the responsibility of the patient's nurse. The findings on survey were discussed with all nurses in the unit meeting following the survey.

The Hospital recognizes the importance of vital signs in assessment and early identification of changes in condition.

ACTION PLANNING:

Immediately following survey, a reminder to all nursing staff regarding the policy vital signs was completed and will be again reviewed in the unit staff meeting in the month of March. The reminder will be provided in face to face meetings on the unit and additionally in written form, via meeting minutes, for staff who could not attend the unit staff meeting.

TIMEFRAME FOR COMPLETION:

The educational initiative will be completed 3/31/2019

MONITORING:

The Unit Nurse Manager on this unit will conduct observations throughout the month of March to ensure that practice meets standards for all patients.

RESPONSIBILITY:

The Nurse Unit Manager is responsible for monitoring of this action plan.

5. The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (e) Nursing services (1) and/or (i) General (6)

Summary of Finding:
Based on observation the facility failed to ensure for 1 of 2 patients on a tube feeding (Patient #26) that the head of bed was maintained at 30 degrees.

Hospital Response:

This finding was observed on the Medical Rehab Unit. The hospital policy on Feed Tubes states that the head of bed is to be elevated 30 – 45 degrees during feedings. The nurse who was observed to provide this care was given feedback by the unit manager on the day of survey. The nurse was familiar with the policy for keeping the head of bed at 30 degrees during tube feeding and knew as soon as it was brought to her attention that she was not following standards. This has not been observed in any other instances with this nurse or others on that unit. The patient did not incur any negative outcome from this occurrence.

The hospital recognizes the importance of preventing patient aspiration while on tube feeding.

ACTION PLAN

An educational reminder to all nursing staff regarding the policy on head of bed elevation for tube feeding patients will be provided in the unit staff meeting in the month of March. The reminder will be provided in face to face meetings on the unit and additionally in written form, via meeting minutes, for staff who could not attend the unit staff meeting.

TIMEFRAME FOR COMPLETION

This educational refresher will be completed by 4/1/2019.

MONITORING

The Clinical Effectiveness Leader on this unit will conduct observations throughout the month of March to ensure that practice meets standards for all patients.

RESPONSIBILITY

The Nurse Clinical Effectiveness Leader is responsible for the monitoring of this action plan.

6. The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (d) Medical Records (3) and/or (e) Nursing Services (1).

Summary of Finding:
Based on clinical record review, interview and policy review the facility failed to ensure for 2 of 4 patients experiencing pain (Patients #25 and 18) that the patient's pain was assessed and/or reassessed and/or that the clinical record reflected the need for an increased dose of morphine and/or a bolus of Versed.

Hospital Response:

The findings in the section pertained to two units; Satellite Unit, located in Hartford, CT and the Respiratory Care Unit located at the New Britain, CT campus.

The hospitals' policy on Pain Assessment and Management includes the requirement that assessment of pain will occur before, during and after any known pain-producing event or procedure. The organization suspects that the assessment did occur in this instance. However, documentation was not present. Being that it is not appropriate or acceptable to retrospectively correct/adjust these finding in the record; the organization will be focused forward on preventing future occurrences. The nurses who did not properly document the pre/post pain assessment in the record were educated at the time of survey. The patient did not incur any negative outcome from this occurrence.

Regarding the finding related to the morphine administration; there was no mechanism at the time of survey to correct this finding or make proactive adjustments as there were no longer any morphine drips active in house. However, the hospital will proactively plan for the next instance of morphine drip. It is hospital policy to provide a reason for administering pain medication. It does not appear that the policy was adhered to in this instance. This patient was a long term patient of the Hospital who in the end stages of life. The staff on the unit cared for this patient for years and took extra measures to ensure she was well cared for at this stage of her life. This patient did not experience any additional pain or suffering as a result of this missing documentation.

ACTION PLAN

The Nurse Clinical Coordinator has been assigned to retrospectively review records for pain assessment pre and post pain medication administration. The findings of these chart reviews will be shared concurrently with the staff on the unit so that they can receive immediate feedback on any improvements that are needed. An educational reminder to all nursing staff regarding the requirements of pain medication assessment will be provided in the unit staff meetings in the month of March. The reminder will be provided in face to face meetings on the unit and additionally in written form, via meeting minutes, for staff who could not attend the unit staff meeting.

A reminder to all nursing staff regarding the policy on titrating pain medication and the importance of rationale will be provided in the unit staff meeting in the month of March. The reminder will be provided in face to face meetings on the unit and additionally in written form, via meeting minutes, for staff who could not attend the unit staff meeting.

TIMEFRAME FOR COMPLETION

This retrospective review activity will be completed by 4/1/2019

MONITORING

The Nurse Clinical Coordinator at the Satellite Unit will conduct observations throughout the month of March to ensure that practice meets standards for all patients.

The Nurse Clinical Coordinator on the Respiratory Care Unit will conduct observations throughout the month of March to ensure that practice meets standards for all patients.

RESPONSIBILITY

The Nurse Clinical Coordinators are responsible for the monitoring of this action plan.

7. The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (e) Nursing Services (1).

Summary of Finding:
Based on clinical record review, interview and policy review the facility failed to ensure for one patient (Patient #18) that care was provider per the plan of care.

Hospital Response:

This finding was specific to the Respiratory Care Unit. The hospital policy is to turn patients every 2-3 hours. The plan of care stated this patient was to be turned q2 hours and in this instance the patient was turned q3 hours. The CNA was made aware of the gap in standards at the time of survey. She acknowledged being aware of the policy. She was reeducated for future reference.

The Hospital recognizes the importance of turning patients to relieve pressure and prevent pressure injuries. This patient did not incur any negative outcome from this occurrence.

ACTION PLAN

A reminder to all nursing and CNA staff regarding the policy for patient turning will be provided in the unit staff meeting in the month of March. The reminder will be provided in face to face meetings on the unit and additionally in written form, via meeting minutes, for staff who could not attend the unit staff meeting.

TIMEFRAME FOR COMPLETION

This educational refresher will be completed by 4/1/2019.

MONITORING

The Nurse Clinical Coordinator on this unit will conduct observations throughout the month of March to ensure that practice meets standards for all patients.

RESPONSIBILITY

The Nurse Clinical Coordinator is responsible for monitoring of this action plan.

8. The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (e) Nursing Services (1) and/or (i) General (6).

Summary of Finding:
Based on observation and interviews during tube feeding administration and/or medication pass it was identified that for 1 of 2 patients (Patient #19) the tube feeding was not administered according to physician orders.

Hospital Response:

This finding was on the Step Down Unit. It is the expectation of the hospital that when a slow bolus is ordered the nurse allow the contents to infuse over 10-45 minutes using the gravity method. In this instance, the nurse observed on this day was taking care not to forcefully or quickly push the tube feeding. However, the policy was not being followed as intended. The Unit Manager provided feedback to the nurse involved at the time of survey. No additional observations of this kind have been made. The patient did not incur any negative outcome from this occurrence.

ACTION PLAN

All nursing staff will receive reminders about how to properly administer a "slow bolus" tube feed during the unit staff meetings in the month of March. The reminder will be provided in face to face meetings on the unit and additionally in written form, via meeting minutes, for staff who could not attend the unit staff meeting.

TIMEFRAME FOR COMPLETION

This educational refresher will be completed by 4/1/2019.

MONITORING

The Nurse Clinical Coordinator on this unit will conduct observations throughout the month of March to ensure that practice meets standards for all patients.

RESPONSIBILITY

The Nurse Clinical Coordinator is responsible for monitoring of this action plan.

9. The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (d) Medical Records (3) and/or (e) Nursing Services (1).

Summary of Finding:
Based on clinical record review and interview with staff for 1 of 3 patient reviewed for suicide risk screening (Patient #10) the hospital failed to ensure that the screen was accurately completed and/or that a Psychologist or Psychiatrist was notified of the results of the screen.

Hospital Response:

The hospital policy states that patients who answer affirmatively to a screening question on history of inpatient psychiatric treatment will receive a follow up suicide risk assessment, environmental check, and assessment by psychology or psychiatry. On the Autism Inpatient unit, patients continuously assessed and seen by both psychiatry and psychology and if there was any concern at all for at suicide ideation or a suicide plan there would be immediate intervention. It appears that in this instance, the psychologist did not specifically document on their assessment tied to the positive suicide screen and therefore a gap in the expected standard was identified. In addition, it appears that staff errantly documented the removal of "pantyhose" from the patient's room when pantyhose were not present in the room to begin with. The staff were likely documenting that ALL items were removed from the room and did not realize that specifically pantyhose did not need to be documented as removed.

At the time of survey this patient was assessed and posed no increased suicide risk. The hospital recognizes the importance of keeping patients in healthcare environments free from harm associated with suicide and suicide attempts.

ACTION PLAN

At the time of survey the Suicide: Management of Patients with Potential policy was already being reviewed and refined to provide clarity and increased involvement by psychology/psychiatry in the environmental assessment and plan. All clinical staff will receive education on the new policy and clarified expectations during the hospitals mandatory spring education. Staff in the Autism Unit will also be receiving communication on the new policy in unit staff meetings in the month of March and Quality Huddles in the month of March. The communications will be provided in face to face meetings on the unit and through the Learning Management System.

TIMEFRAME FOR COMPLETION

An initial round of education on the policy clarifications was conducted in February 2019.

The unit based staff meetings and Quality educational huddles will be completed by 4/1/2019.

The educational initiative in the Learning Management system will be completed by 6/1/2019.

MONITORING

The Director of Risk Management and Quality will complete reviews of the medical record in the Autism Unit to ensure that that new processes are being followed and documentation of actions taken is complete

RESPONSIBILITY

The Director of Risk Management and Quality will be responsible for monitoring this action plan.

10. The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (d) Medical Records and/or (e) Nursing Services (1).

Summary of Finding:
Based on clinical record review, and interview the facility failed to ensure that for one of three patients (Patient #26) with wounds that the dressing orders were accurately transcribed.

Hospital Response:

The organization currently has a hybrid paper and electronic medical record. There is an ongoing effort to provide ordering providers with additional and follow up education on navigating the new ordering processes. At the time of survey, the nurse was referencing a standard paper treatment plan which did not specify the level of detail as was available on the electronic order. Nursing does not currently utilize electronic treatment orders or plans. The ordering provider had errantly entered the treatment order electronically. This created the gap in dressing change frequency. The treatment plan was immediately updated to reflect the intention of the order. The organization recognizes that heightened awareness and cross check is needed during this time of transition.

The patient did not incur any negative outcome from this occurrence.

ACTION PLAN

The unit based clinical leadership has initiated a review of all new admission orders to ensure that reconciliation between any paper orders and electronic orders has taken place and no treatment orders are overlooked. Providers are receiving ongoing communication in meetings and individualized sessions about order entry and the electronic record system transition.

TIMEFRAME FOR COMPLETION

Medical staff refreshers on the EMR and order entry process were conducted in a variety of methods throughout February 2019 including in group sessions and one-to-one reviews.

Unit leadership has begun reviewing all admission orders. This is an active and ongoing process which will continue minimally through 5/1/2019.

MONITORING

The new admission orders will be monitored over the month March and April to ensure no additional opportunities are identified.

RESPONSIBILITY

The Nurse Unit Managers and Nurse Clinical Coordinators are responsible for monitoring this action plan.

11. The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (d) Medical Records (3).

Summary of Finding:
Based on clinical record review, interview and policy review the facility failed to ensure that for three records reviewed that an accurate clinical record was maintained.

Hospital Response:

The findings in this section were related to three units.

On the Medical Rehab Unit there was improper documentation of Intake and Output. Hospital policy states that all caregivers are responsible for recording I&O. However, it is the responsibility of the licensed nursing staff to ensure documentation has occurred. In this instance, there appears to be a disconnect between the licensed nursing staff holding the tube feeding and the non-licensed staff documentation. The Unit Nurse Manager reeducated the staff members at the time of survey regarding the gap in policy.

On the Satellite Unit there was a finding related to documentation of medication administration. It is the hospital's policy to document all administration of medication in the MAR. During this time, staff was newly using the electronic medical record for medication administration documentation. With this significant workflow change it appears that the documentation was overlooked. It is the hospital's policy

that all medications are to be documented on the medication administration record.

On the Respiratory Care Unit there was a finding related to documentation of the patient's bed bath. The hospital standard of care for hygiene protocol is to receive bathing according to patient preference or otherwise per care plan. The gap in the standard was brought to the intention of the CNA at the time of survey. The CNA reported that the patient did receive a bed bath on these dates but had not documented as such. The CNA was counseled on the importance of accurately documenting care.

On the Respiratory Care Unit there was a finding regarding a morphine drop. At the time of survey, reconciliation was completed using the pharmacy narcotic reconciliation records to ensure that there was not a gap in actual administration of the prescribed Morphine. No administration gap was identified. This finding is a documentation gap in the medication administration record. During this time, staff was newly using the electronic medical record for medication administration documentation. With this significant workflow change it appears that the documentation was overlooked. It is the hospital's policy that all medications are to be documented on the medication administration record.

ACTION PLAN

A reminder to all nursing and CNA staff regarding the policy intake and output documentation for held tube feeding will be provided in the unit staff meeting in the month of March. The reminder will be provided in face to face meetings on the unit and additionally in written form, via meeting minutes, for staff who could not attend the unit staff meeting.

All nurses in the hospital are completing medication re-competency assessment to ensure the documentation matches administration of medication per hospital policy and standards of care. This activity will assist nurses with continuing to build familiarity with navigating the new electronic medical record, which includes medication administration. At the time of survey this was a very new process to staff.

A reminder to all CNA staff regarding the documentation for bed baths will be provided in the unit staff meeting in the month of March. The reminder will be provided in face to face meetings on the unit and additionally in written form, via meeting minutes, for staff who could not attend the unit staff meeting.

TIMEFRAME FOR COMPLETION

Both educational refreshers will be completed by 4/1/2019.

This re-competency will be completed by 4/1/2019.

MONITORING

The Nurse Clinical Effectiveness Leader on the Medical Rehab Unit will conduct observations throughout the month of March to ensure that I&O practice meets standards for all patients.

The Nurse Clinical Coordinator on the Satellite Unit will conduct observations throughout the month of March to ensure that medication administration practices meets standards for all patients.

The Nurse Clinical Coordinator or Nurse Unit Manager on the Respiratory Care Unit will conduct observations throughout the month of March to ensure that bed bath practice meets standards for all patients.

In the event of a Morphine drip starting again at Hospital for Special Care, the Nurse Clinical Coordinator will monitor the documentation process to ensure that practice meets standards for all patients.

RESPONSIBILITY

The Nurse Clinical Effectiveness Leader and Nurse Clinical Coordinators are responsible for monitoring of this action plan.

12. The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (f) Diagnostic and therapeutic facilities and/or (i) General (6).

Summary of Finding:
Based on the medical record review, review of facility documentation, review of facility policies, observations and interviews for one of two patients reviewed for radiological services (Patient #22 and Patient #23), the facility failed to ensure that the lead shielding use during the procedure was documented.

Hospital Response:

The hospital policy commits to following the ALARA (As Low as Reasonably Achievable) safety measures for mitigating external radiation hazards. These principles include;

1. Time. Minimize your time of radiation exposure
2. Distance. Double the distance between your body and the radiation source to divide the radiation shielding exposure
3. **Shielding**. Use of absorber material such as lead is an effective way to reduce radiation exposures and protect patients and staff. Types of lead shielding are; lead aprons, lead gloves, thyroid shields, and portable or mobile lead shields.

Radiology services at Hospital for Special Care are provided through contracted clinical services. In coordination with our partners, Hospital for Special Care has worked to ensure that the documentation in the medical record for radiology services will now completely reflect the shielding measures in place for each patient encounter.

ACTION PLAN

The organization and our partner contracted radiology provider group has educated and communicated to the radiologic technologist providing service that it is the expectation that they document the use of protective shielding of all patients receiving imaging exams that utilize ionizing radiation as long as such shielding does not interfere with the x-ray beam or anatomical area in question.
A "hard stop" has been implemented into the imaging workflow that requires a yes/no answer to be recorded in the Electronic Medical Record (EMR) prior to completion of the imaging exam.
Education to the technologist was completed on the modifications to the EMR making the hard stop part of the imaging workflow.

TIMEFRAME FOR COMPLETION

The imaging staff was educated on the requirement to document the use of protective shielding on 1/16/2019. The EMR changes were put into place 2/11/2019.

MONITORING

The Manager of Diagnostic Imaging for the contracted radiology provider will monitor the use of protective shielding for imaging exams done at The Hospital for Special Care. This will be done through the use of a report within EPIC (EMR).

RESPONSIBILITY

It will be the responsibility of the Manager of Diagnostic Imaging to monitor the documentation of the use of protective shielding for patients receiving imaging studies at the Hospital for Special Care.

13. The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (f) Diagnostic and therapeutic facilities and/or (i) General (6).

Summary of Finding:
Based on observations during tour of the Department of Radiology, the hospital failed to ensure that appropriate signs were posted to ensure safety.

Hospital Response:

The hospital had signage in place at the time of survey on the main door into the Radiology suite where the permanently fixed equipment is located. This signage need to be updated and additional entry doors to and within the suite needed to be marked. The room where permanently fixed equipment that emits ionizing radiation is located has been evaluated for all points of entry.

ACTION PLAN

The required signage as indicated in R.C.S.A 19-24-8 (5)(C) has been affixed to those entry points. New signage has been installed as required to be in compliance with R.C.S.A 19-24-8 (5)(C). Caution signs have been placed on all entry points to the x-ray examination room. This includes the door from the common hallway (patient/staff entrance), the door from the technologist work area, the inside of the bathroom door, the inside of the store room door and the entrance from the control room into the imaging room.

TIMEFRAME FOR COMPLETION

The correct caution signs were posted by the end of business day on 1/16/2019.

MONITORING

The Manager of Diagnostic Imaging, or their designee, will actively verify that all required caution signs are posted as required in R.C.S.A 19-24-8 (5)(C). If any signs are found to be missing or damaged in any way they will be replaced immediately.

RESPONSIBILITY

Compliance with R.C.S.A 19-24-8 (5)(C) will be the responsibility of Manager of Diagnostic Imaging.

14. The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (i) General (6).

Summary of Finding:
Based on a tour of the hospital and staff interview, the hospital failed to ensure that the physical environment was designed and constructed to maintain the safety of patients with suicidal tendencies and/or tendencies to cause harm to themselves or others. Specifically, lacked institutional fasteners throughout for window and door frames;

Hospital Response:

Immediately following survey efforts began to correct this concern with the goal of replacing all fasteners with tamper resistant institutional fasteners. The organization takes seriously all measures and requirements to the prevent suicide and suicidal attempts in our facility. The organization regularly assesses risk to our patients and makes adjustments when deficiencies are found.

ACTION PLAN

The hospital has replaced all fasteners with tamper resistant institutional fasteners. All regular fasteners will be replaced with tamper resistant institutional fasteners. The Director of Engineering has inspected all areas of the Autism Inpatient Unit and Neurobehavioral Unit 3.

TIMEFRAME FOR COMPLETION

The replacement of all fasteners with tamper resistant institutional fasteners has been completed on 2/28/2019.

MONITORING

Hazard Surveillance Rounds will be conducted to monitor the completion on ongoing compliance with this action plan

RESPONSIBILITY

It is the responsibility of the Corporate Director of Engineering to ensure completion of this action plan.

15. The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (i) General (6).

Summary of Finding:
Based on a tour of the hospital and staff interview the hospital failed to ensure that the physical environment was designed and constructed to maintain the safety of patients with suicidal tendencies and/or tendencies to cause harm to themselves or others. Specifically, the presence of an electrical adjustable bed;

Hospital Response:

The hospital has had a longstanding practice of providing only mitigated hospital beds or behavioral health beds in the Neurobehavioral units which had cords no longer than 3 feet. The hospital recognizes the importance of ensuring that measures put into place to prevent suicide attempts and suicide are maintained. At the time of survey, it appears that this measure was not in place as is the intention.

ACTION PLAN

All electric beds with electrical cords in excess of three feet long are not permitted on the behavioral units. Specially designed Behavioral Health Beds with removable cords that are not left in the patient room have replaced those beds in the rooms at the time of survey. These beds will be used when a determination has been made that the patient requires a hospital bed as opposed to the standard Behavioral Health box bed. Policy review has been completed and staff education on the environmental solvency for preventing suicide is underway and ongoing.

TIMEFRAME FOR COMPLETION

The removal of the inappropriate beds was completed on 1/10/2019. Education is ongoing through the spring of 2019.

MONITORING

Hazard Surveillance Rounds will be conducted to monitor the completion on ongoing compliance with this action plan

RESPONSIBILITY

It is the responsibility of the Corporate Director of Engineering to ensure completion of this action plan.

While individual responsibility is assigned at the unit leadership level, all action plans and monitors outlined in this response are the collective responsibility of the Vice President of Nursing, Chief Nursing Officer, the Vice President of Quality, Risk Management, Patient Safety Officer and the Vice President of Facilities and Hospitality. Together, the hospital will ensure all areas identified are improved for the safety of our patients and the population we serve.

Respectively submitted:

Lynn Ricci

Lynn Ricci
President
Hospital for Special Care